

# VISIONS

NAATP Visions is the official newsletter of the National Association of Addiction Treatment Providers (NAATP),

MARCH, 2004

## NAATP ANNUAL CONFERENCE COMMITTEE INTITES YOU TO TAMPA, FL

**M**ost of us have experienced a brutal winter this year and are desperately seeking an escape to sunshine. Well, do I have an opportunity for you!

This year the 2004 NAATP Addiction Treatment Leadership Conference is being held at the Marriott Waterside Hotel in sunny, warm Tampa, Florida. The dates are May 15 - May 18.

The Leadership Conference, this year, promises to be one of the best ever. So, not only will you get that much sought after sunshine, you will have an opportunity to make new friends, network, and to learn a lot. We have a balanced program which focuses on leadership and administrative issues but also on issues that will be of interest to clinicians and medical staff of our facilities as well.

We will begin the conference with a new perspective on leadership and move from there to look at opportunities to integrate research findings into daily

opportunity to meet colleagues from around the country.

You will not want to miss any of these sessions. I suggest that you schedule additional time at either end of the conference, or perhaps at both ends, to play golf or visit Disney World or Busch Gardens.

On behalf of the NAATP Board of Directors and Conference Committee, I invite you to join us in Florida for fun, sun, fellowship, and professional insights you'll not likely get anywhere else.

**Ken Ramsey, Ph.D., President/CEO  
Gateway Rehabilitation Centers  
NAATP 2004 Conference Chair**

### 2004 Conference Committee Members:

- Peter Asmuth,
- David Rosenker,
- Cathy Palm,
- Nancy Murray,
- Leah Brick,
- Ed Diehl,
- Janis Waddell,
- Russ Hagen, J
- Jim Hall,
- Carl Kester,
- Renée Popovits,
- Doug Brush



practice, and get a briefing on news from the federal government. We will have a special track for physicians. Our CEO Round Table will feature a dynamic discussion about developing a strategy to "manage" the managed care organization in your state. We will present the Nelson J. Bradley Award, the ACATA Administrator of the Year Award, and the Michael J. Ford Journalism Award. On Monday evening, we will have a dinner cruise that will be reasonably priced and an exciting

**You will not want to miss this exciting 2004 conference that will feature John Stahl-Wert, Dr. David Lewis, Dr. Michael Brooks, Michael Flaherty, Darryl Strawberry, Dr. Andrea Barthwell, Dr. Jim Mulligan, Dr. Paul Earley and so much more.**

**Be sure to register and include the Saturday Golf outing in your registration, as well as, the Monday evening Dinner Cruise. All of this happens at the 2004 NAATP Annual Leadership Conference in**

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ISSUE

**E**ach spring the members of the National Association of Addiction Treatment Providers select peers to serve on the board of directors for a three year term. In 2003, the NAATP by-laws were updated and the board terms were developed and a wider representation on the board was established. This is a very important process for the membership in that the NAATP board provides direction and oversight to the operations of the National Association of Addiction Treatment Providers. It has been my privilege to have worked with outstanding board members since my tenure as the NAATP executive in 1997 and the slate for this year and the class of 2007 is another strong listing of NAATP members.

The ballots for this election have been mailed and should have reached your desk if you are the organizations designated representative or if you are an ACATA member or individual member of NAATP. If you have not received your ballot, be sure to contact aabshire@naatp.org and request a ballot be sent to you and you can return it to the NAATP office by April 30, 2004. The seven (7) individuals being nominated for a three (3) year term are:

- 1 **Doug Brush, CEO Metro Atlanta Recovery Residences, Atlanta, GA**
- 2 **James Dougherty, Senior VP, Marworth Treatment Center, Waverly, PA**
- 3 **Jerry Crowder, President/CEO, Bradford Health Services, Birmingham, AL**
- 4 **Dennis Gilhousen, President/CEO, Valley Hope Association, Norton, KS**
- 5 **William Hartigan, President/CEO, Liberty Management Group, Ramsey, NJ**
- 6 **James Moore, Executive Director, Cumberland Heights, Nashville, TN**
- 7 **Art VanDivier, Executive Director, La Hacienda Treatment Center, Hunt, TX**

These nominations for the class of 2007 represent geographic diversity, program diversity and considerable experience in the field of addiction treatment health care.

Page Two, as some wise sage one said is that the deadline for returning your benchmark forms is rapidly approaching. That infamous date of April 15 is the deadline for submitting your data for the 2004 benchmark process. If you have not participated in the past, you have missed the opportunity to examine your operations in respect to other National Association of Addiction Treatment Providers members. By doing this you are able to ask the key and informative questions about your processes and work to ensure that you are delivering the highest quality treatment possible. Once all the data has been submitted, graphs will be developed so that you will be able to look at your information in

“**benchmark**” fashion with the other participants. We have made it easy this year for you to enter your information on line and you may do so at <http://survey.naatp.org>. If you do not have your login name or your password, contact aabshire@naatp.org to secure this information. Of course, you may also complete the survey in the traditional “paper” form and send it to the NAATP office. This form can be secured by going to [www.naatp.org/survey/04benchmarksurvey.phtml](http://www.naatp.org/survey/04benchmarksurvey.phtml) and then clicking on the icon to download and print the form. If you have any questions, just contact the NAATP office and we will be sure to help you with this most important project.

And finally, one of the topics that you will hear quite often at the annual conference in Tampa is **Managed Care**. That is right; the 1990’s have reinvented themselves pretending to be the 2000’s. The issue of managed care is once again on the radar screen, on the table of the NAATP Board Meetings, on the agenda of the NAATP Executive and scheduled for inclusion at the Annual Conference. The way in which employer sponsored health care plans are managed, limited and interpreted is of great concern to the membership of NAATP. As the rhetoric continues to increase around the need to address a comprehensive look at health care delivery and payment in this country, the behavioral care continues to significantly limit our ability to demonstrate how addiction treatment, good clinically sound and efficient addiction treatment, contributes to the overall reduction of health care costs.

The issues of *medical necessity, criteria, fail outpatient first*, and many more are not just hot button issues, they are issues that impact the way you do business, the way you get paid and the way in which individuals access or do not access their benefits. At the annual conference, the CEO roundtable will focus on developing a **managed care plan** in much the same way that you have an evacuation plan, a strategic plan, etc. We need and must have a plan to ensure that the managing of health care does not deteriorate to simply managing costs without looking at the consequences. The National Association of Addiction Treatment Providers is and will be a clear voice for appropriate management of care for those persons with addictive disease disorders!

**THAT’S THE PERSPECTIVE OF RJH**

# NEW DRUG THERAPY SHOWS PROMISE IN TREATING ADDICTION

*By Ronald Pike, M.D.  
Medical Director, AdCare Hospital  
Worcester, Massachusetts*

Right now, according to the National Institute on Drug Abuse (NIDA), more than a million Americans are addicted to opiates. This class of drugs includes not only heroin, the most widely abused of all opium derivatives, but also commonly prescribed pain medications such as OxyContin, Vicodin, Dilaudid and Demerol. Of tremendous concern is the use of these drugs among young people – although a U.S. government survey demonstrated an 11 percent overall decline in drug abuse in students aged 13-18 between 2001 and 2003, illegal use of narcotic pain medications in that population is on the rise.

## *First steps to recovery*

Typically, the road to recovery for any opiate addict starts with detoxification – getting the drug out of your system. But because withdrawal from the drug can produce symptoms that are uncomfortable, detox is best accomplished under medical supervision, with the administration of medications that manage withdrawal symptoms. Detox can take from several days to a few weeks, and represents the first step in a comprehensive treatment program that includes behavioral-based therapy and, when indicated, maintenance therapy in the form of medication to help minimize cravings.

The U.S. Food and Drug Administration's approval in late 2002 of two new drugs – Subutex and Suboxone – for use in treating opiate addiction presents new opportunities and expanded treatment options for addicts and health-care professionals.

Subutex and Suboxone have as their basis a narcotic called buprenorphine, previously employed exclusively as a pain medication that is administered by injection. Subutex contains only buprenorphine, and is given to patients during the initial phase of detoxification, under direct medical supervision, to manage withdrawal symptoms. Suboxone contains both buprenorphine and naloxone. This combination decreases the possibility of injection because the naloxone will make the patient go into withdrawal. Suboxone is also administered during detox, and has been shown to be very effective when used for subsequent maintenance. Both drugs are available in pill form, and are taken sublingually – that is, the pill is placed under the tongue and remains there until it dissolves.

## *Advances in opiate replacement therapy*

How is buprenorphine therapy different from methadone, for decades considered the gold standard in opiate-replacement therapy?

A key differentiator with buprenorphine therapy, specifically Suboxone, is that it can be dispensed in a doctor's office. With methadone, patients are required to go to a specially licensed hospital or clinic, often on a daily basis. This is very disruptive, and frequently prevents people from moving forward with their lives. Holding down a job, for instance, can be tough if you've got to go to a methadone clinic every day

and spend time waiting in line for your medication. It's easier and less disruptive for patients to get the prescription from their own doctors and take the medication on their own. Plus, some patients are concerned that friends or business associates might see them coming out of a methadone clinic. With buprenorphine, they can maintain their privacy by getting the medication from their primary care doctors.

In addition, Suboxone a narcotic and longer-acting than methadone, and studies reveal that the likelihood of abuse, addiction and overdose are far less with buprenorphine. It satisfies the craving for narcotics. Buprenorphine is safer than methadone because the ceiling dose associated with its partial agonist nature, can be reached and overdose problems are minimal. Where as heroin and methadone are agonist but do not have the ceiling effect and doses can be raised to dangerous levels and overdose. In fact, Suboxone and Subutex are taken sublingually with its own advantages. Attempting to inject the medication will trigger severe withdrawal symptoms because of the addition of narcan making Suboxone.

## *Meeting new challenges*

Given the large number of opiate addicts in the United States today, and the fact that there's a limited number of spots for patients seeking methadone maintenance, we needed a viable treatment alternative to methadone. With buprenorphine, we have that alternative. And as more people start buprenorphine therapy, more methadone spots will open up for those who choose that route. So, this really expands treatment options for opiate addicts. Detoxification use of the buprenorphine also has its advantages with safety and the ability to use in doctors offices. Methadone does not have those advantages for detoxification.

Still, there are challenges – not the least of which is the cost of buprenorphine, which can run from \$3-\$5 per pill. Detoxification can cost \$20 per dose for medications plus doctor visits with an approximation of \$400 just for the medication. Maintenance therapies will be even higher with \$300-\$400 per month for many months. Some insurers do cover the cost of detox and the maintenance.

In addition, availability of buprenorphine therapy is extremely limited at present. To prescribe the medication, physicians must complete an eight-hour training program and be certified by the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration. As of October 2003, fewer than 2,000 doctors nationwide were certified to dispense buprenorphine for use in addiction treatment. Under current federal guidelines, each certified doctor can take only 30 buprenorphine patients at any one time. And if a certified doctor is part of a medical practice group, even if other physicians in the group are certified, the group is perceived under the guidelines as one entity. Thus, the entire practice group cannot take more than 30 patients. As word

CONTINUED ON PAGE 6

One of the best things  
in New York has a  
brand-new name.



The Smithers Alcoholism Treatment and Training Center is now **The Addiction Institute of New York**. Our new name reflects our commitment to providing state-of-the-art, evidence-based treatment, training of professionals, and research on addictive disorders. Our facility—one of the top addiction treatment centers in the country—provides the widest range of addiction treatment programs and services available today.

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[www.AddictionInstituteNY.org](http://www.AddictionInstituteNY.org)

## Substance Abuse and Mental Health Services Administration Announces Availability of Access to Recovery (Drug Treatment Voucher) Program Funding Applications

On March 4<sup>th</sup>, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced the availability of official funding applications for the Access to Recovery (ATR), or Drug Treatment Voucher Program. The program is a new \$100 million competitive grant program for states that will allow them to design and implement federally supported voucher programs to pay for a range of effective, community-based alcohol and drug treatment and recovery support services. The grants are intended to promote individual patient choice among a range of service options. Additionally, the grants are intended to expand access to care, including access to faith- and community-based programs, and increase overall drug and alcohol treatment service capacity.

SAMHSA has identified a State's ability to ensure genuine, free, and independent choice among eligible providers as one key element to implementing an effective ATR program. Additionally, States are encouraged to support any mixture of clinical drug and alcohol treatment and recovery support services that will achieve the program's goal of cost-effective, successful outcomes for the largest number of individuals.

The Access to Recovery Program emphasizes both accountability and demonstrated effectiveness, requiring states to create an incentive system for positive outcomes and to take active steps to prevent waste, fraud and abuse. Program success will be measured by seven specific outcomes:

- abstinence from drugs and alcohol
- no involvement with the criminal justice system
- attainment of employment or enrollment in school
- social supports
- access to care
- retention in care
- and stable housing

By assessing the scope and outcomes of the program, grantees will discover what works best and adjust their programs accordingly, including changing their list of eligible ATR providers based on program performance. SAMHSA will evaluate overall program effectiveness and utility nationwide.

The ATR program anticipates making awards of up to \$15 million per year for each of three years, to states and tribal organizations that compete successfully. The Administration has requested an additional \$100 million in its FY 2005 budget request, which would double the ATR budget to \$200 million. If this funding is appropriated by Congress, it would allow SAMHSA to provide additional states with ATR funding in FY 2005 and possibly in future years.

SAMHSA is hosting four regional technical assistance

meetings for applicants who wish to apply for ATR funding. These meetings will be held on:

March 26<sup>th</sup> in the Northeast  
April 1<sup>st</sup> in Atlanta, Georgia  
April 13<sup>th</sup> in Phoenix, Arizona  
April 15<sup>th</sup> in Seattle, Washington or in Denver, Colorado (location TBD)



Additionally, SAMHSA will accept questions from applicants and provide technical assistance on an individual basis.

Applicants have until June 4, 2004 (90 days from the date of announcement) to submit their ATR grant applications to SAMHSA.

Copies of the applications are available at [www.atr.samhsa.gov](http://www.atr.samhsa.gov) or from SAMHSA's clearinghouse at 1-800-729-6686. SAMHSA expects that once grant applications are submitted, that they will be reviewed quickly and that awards could be made as early as August, 2004.

## Results! Not Promises

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spreads throughout the addict community, waiting lists get longer and longer. We hope the 30-patient limit will be expanded in the future, though.

Another problem is the possibility of diversion to other addicts for detoxification or their own addiction. This will be followed closely over the ensuing years.

### Next steps

AdCare Hospital in Worcester has been treating addiction for more than 20 years. Our treatment philosophy is that addiction is a biopsychosocial disease that affects not only the individual addict, but also that person's family and the community in which the addict functions. As the health-care landscape in the United States has evolved, we have evolved with it - making efforts to remain on the cutting edge of treatment. In fact, AdCare is on the list of The 100 Best Treatment Centers for Alcoholism and Drug Abuse researched and written by Linda Sunshine and John W. Wright.

So, of course, we're quite enthusiastic about the prospect of opening up buprenorphine therapy to patients in our treatment region. Preparations are underway to begin a buprenorphine program at AdCare by spring 2004 - including hiring additional staff and establishing guidelines for screening patients. We also will seek the necessary information from the American Society of Addiction Medicine to begin conducting the required eight-hour training program for doctors in Massachusetts who are interested in dispensing buprenorphine. The training, which will be conducted right here at AdCare, will be available not only to physicians who specialize in addiction care, but also to primary care doctors, family practitioners, and psychiatrists certified in addiction medicine. By increasing the number of doctors who are qualified to prescribe buprenorphine, we can offer assistance to a much wider population.

This potential to provide treatment to more addicts is certainly very exciting. And as a health-care professional, I find it gratifying to see addiction perceived as a treatable disease, much like diabetes, that frequently requires maintenance medication to keep symptoms in check. But it's important to note that for addicts, medication alone is not a panacea. These patients also need recovery and relapse-prevention skills, and these can be learned through such activities as behavioral-based therapy, counseling, and participation in 12-step programs.

For more information about buprenorphine, Subutex and Suboxone, including a state-by-state listing of qualified physicians, visit the SAMHSA buprenorphine Web site at <http://www.buprenorphine.samhsa.gov/index.html>. The Web site features information for consumers and health-care professionals, including links to other resources. Or, contact the U.S. Department of Health and Human Services at (877) 697-6775 (toll free), or (202) 619-0257.

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**DO YOU KNOW WHERE YOUR NAATP BENCHMARK SURVEY FORM IS? THE NAATP OFFICE CAN HELP YOU FIND ANOTHER ONE IF YOU CANNOT FIND YOUR FORM. CONTACT [AABSHIRE@NAATP.ORG](mailto:AABSHIRE@NAATP.ORG) FOR A FORM TODAY!**

**THE COMPLETED FORM NEEDS TO BE  
RETURNED TO THE NAATP OFFICE BY  
APRIL 15!**

**C**ity mayors, economic development leaders, and school administrations all around our country have identified school quality as a major factor that helps to determine the economic and social health of their communities. In many cities benchmarks such as achievement test scores on state-mandated tests and measured quality of educators are on the forefront of discussions. As you listen to discussions about school quality do you wonder what impact the disease of alcohol and drug addiction has on schools? How many children are high when they are taking achievement tests? How are teachers prepared to have recovering children in their classrooms?

Fairbanks and the University of Indianapolis have begun a formal collaborative initiative around the issue of substance-impacted children and schools. We are focusing on children who are using substances or who were subjected in utero to substances, and children who have or had a parent who has the disease of substance abuse. The mission of our initiative is “to provide schools and other child-serving agencies with practical, effective strategies and tools to address the school problems of substance-impacted children by building each child’s developmental capacities for school and life success.”

Our first study was recently completed by Fairbanks’ clinical specialist, Sigurd Zielke and Susan Zapach, fellow at University of Indianapolis Center of Excellence in Leadership Learning. The results may be of interest to other NAATP members as you explore areas of service and advocacy in your communities.

The purpose of the study was to gain knowledge of the performance and school behavior of substance-impacted children from a practitioner point of view. We invited school educators from ten elementary schools to participate in focus groups. An analysis of the focus group narratives provided five major findings: 1) The educators readily identified substance-impacted children. They knew that certain children with learning or behavior issues were environmentally or biologically affected by

caregiver drug or alcohol abuse. 2) The participants identified a variety of notable academic/learning problems including poor academic performance, information processing, memory, motor and language difficulties. ADHD behaviors, task perseverance and motivation issues were also identified. 3) Substance-impacted children presented distinct disruptions in terms of their general school behavior. The educators associated aggressive behavior, boundary problems, lack of control, withdrawal and sadness with children they identified as substance-impacted. They saw these behaviors contributing to classroom management and school discipline issues. 4) When asked, educators readily identified actions they could take to provide a more productive and positive school experience for these children. Included was promoting consistency and structure, routine and predictability, security and civil interaction between teacher and child. 5) Because the schools lacked resources and strategies, teachers did see much hope regarding addressing the issue of substance-impacted children.

We plan to continue our dialogue with schools and to do further study in order to identify the prevalence of substance-impacted children and the full range and specific nature of their learning problems. We want to know why some of the impacted children do not manifest learning or behavior problems and how the issue relates to the school climate, culture and overall school performance on state-mandated testing. Information updates on the progress of our studies will be posted on Fairbanks website, [www.fairbanksed.org](http://www.fairbanksed.org).

**HELENE M. CROSS**  
**PRESIDENT AND CHIEF EXECUTIVE OFFICER**  
**FAIRBANKS**  
**NAATP BOARD MEMBER**

## UPCOMING EVENTS FOR YOUR CALENDER

The **Haymarket Center** will present the 2004 Spring Workshop Series **Feb 21 to April 24 (selected Saturdays) in Chicago**. For more information, contact Carol Blyskal at (312) 226-7984, ext. 314 or visit [www.hcenter.org](http://www.hcenter.org).

The **Ben Franklin Institute** will hold the Third National Adolescent Conference, "Focus on the Future of our Youth," **March 31 to April 3 in Newport Beach, Calif.** For more information, call (800) 643-0797 or visit [www.BFIsummit.com](http://www.BFIsummit.com).

The **National Center on Addiction and Substance Abuse (CASA)** at Columbia University will hold a CASACONFERENCE, "Family Matters - Substance Abuse and the American Family," **April 29 in New York**. For more information, visit [www.casacolumbia.org](http://www.casacolumbia.org).

The **American Society of Addiction Medicine (ASAM)** will hold its 35<sup>th</sup> Annual Medical-Scientific Conference **April 22 to 25 in Washington, DC**. For more information, call (301) 656-3920 or visit [www.asam.org](http://www.asam.org).

**Substance Abuse Librarians & Information Specialists (SALIS)** will hold its 26<sup>th</sup> annual conference **April 20 to 24 in Berkeley, CA**. For more information call (510) 642-5208 or e-mail [salis@arg.org](mailto:salis@arg.org).

The **Inaugural UK/European Symposium on Addictive Disorders (UKESAD)** will be held **April 29 to May 1 in**

**Central London, England**. For more information email: [ukesad@addictiontoday.co.uk](mailto:ukesad@addictiontoday.co.uk).

The **National Association of Addiction Treatment Providers** presents the 2004 NAATP Annual Addiction Treatment Leadership conference **May 15-18, 2004 in Tampa, FL**. For more information call (717) 392-8480 or visit [www.naatp.org/conferences/annualconference.php](http://www.naatp.org/conferences/annualconference.php).

The **National Association of Drug Court Professionals** will hold its 10<sup>th</sup> Annual Drug Court Training Conference **June 2 to 5 in Milwaukee**. For more information, call (877)266-1374 or (703)575-9522, email [dshultheiss@nadcp.org](mailto:dshultheiss@nadcp.org) or visit [www.nadcp.org](http://www.nadcp.org).

The **Haymarket Center** will present its 10<sup>th</sup> Annual Summer Institute on Addictions **June 16 to 18 in Chicago**. For more information, visit [www.hcenter.org](http://www.hcenter.org).

The **College of Problem Drug Dependence (CPDD)** will hold its 66<sup>th</sup> Annual Meeting **June 12 to 17 in San Juan, Puerto Rico**. For more information, call (800)759-5800 or visit [www.cpdd.vcn.edu](http://www.cpdd.vcn.edu).

The **National Association of Addiction Treatment Providers** presents the **South East Conference on Addictive Diseases (SECAD) in Atlanta, GA, December 1-4, 2004**. For more information, visit [www.naatp.org/secad](http://www.naatp.org/secad)

# NAATP VISIONS

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V I S I O N S

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